RATHBONE
CHIROPRACTIC CENTER, PC
ROBERT M RATHBONE, DC
4055 SW 185th, Suite 200
Aloha. OR 97078-1567

CONFIDENTIAL PATIENT INFORMATION

First & Last Name, Middle Initial _____ Date of Birth _____

Address _____ City _____ State_____

Zip _____ Cell Phone _____ Home Phone _____ Work Phone _____

You may leave messages for me on my phone, answering device, and/or with a family member. Yes / No

Marital Status _____ Employer Name _____

Do you have insurance? YES / NO *If yes, complete the following:*

Medical Ins. Co. _____ Subscriber Name_____

Subscriber ID# _____ Subscriber Date of Birth _____

Group Number _____ Your relation to subscriber: self / spouse / dependent

Is there secondary insurance? YES / NO *If yes, complete the following:*

Secondary Ins. Co. _____ Subscriber Name _____

Subscriber ID# _____ Subscriber Date of Birth _____

Group Number _____ Your relation to subscriber: self / spouse / dependent

List medications you are taking _____

_____

Did you consult other doctors? Yes / No If yes, please list_____

_____

Who referred you to our office? _____

For Women: Date last menstrual cycle began _____ Are you pregnant? Y/N

MEDICARE PATIENTS ONLY, complete this line - SS#

I, the undersigned, do hereby authorize Rathbone Chiropractic Center, PC doctors, associates, or assistants to perform upon me examination and diagnostic procedures arising from any current or presently unforeseen conditions, which Rathbone Chiropractic Center, PC doctors, associates, or assistants may consider necessary advisable in the course of my health.

I understand and agree that Rathbone Chiropractic Center, PC doctors, associates, or assistants have the right to refuse to accept me as a patient at any time.

_____

Patient Signature **Date**

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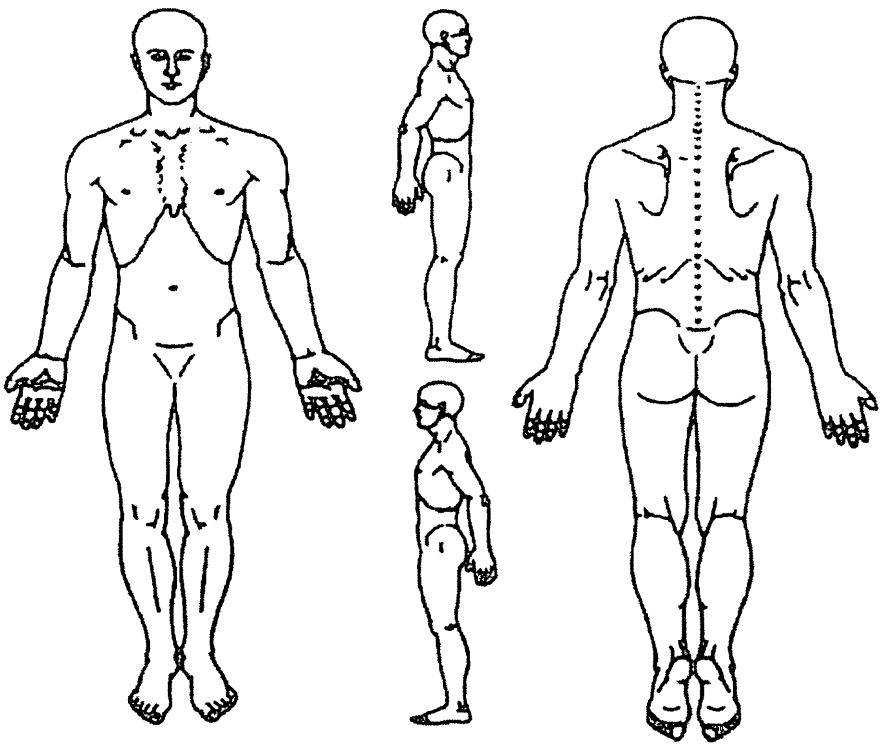
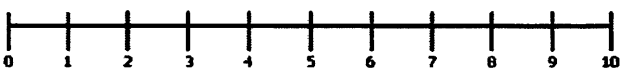
WRITE THE APPROPRIATE LETTER(S) AT THE LOCATION(S) WHERE YOU ARE EXPERIENCING PAIN OR DISCOMFORT ON THE IMAGES BELOW.

B=Burning **C**=Cramping **D**=Dull **N**=Numb **S**=Stabbing/Cutting **T**=Tingling



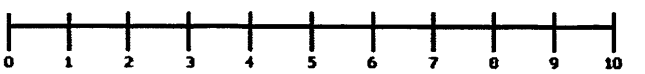
ON THE SCALES BELOW, PLEASE DRAW AN "X" ON THE SPOT THAT BEST REPRESENTS YOUR PAIN OR DISCOMFORT.

*Rate the pain you have right NOW:



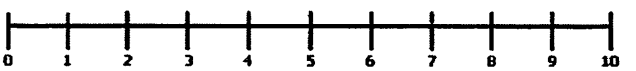
No Pain — Moderate Pain — Worst Pain Possible

*Rate your AVERAGE pain in the last week:



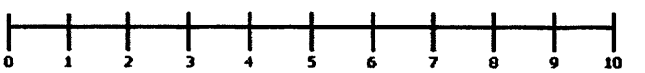
No Pain — Moderate Pain — Worst Pain Possible

*Rate your pain at its BEST in the past week:



No Pain — Moderate Pain — Worst Pain Possible

*Rate your pain at its WORST in the past week:



No Pain — Moderate Pain — Worst Pain Possible

Patient Name _____ **Date of Birth** _____

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Consent for Use and Disclosure of Health Information

SECTION A: PATIENT GIVING CONSENT

Name: _____ Phone _____

Address: _____

_____

SECTION B: TO THE PATIENT—this notice describes how medical information about you may be used and disclosed and how you can get access to this information PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: **By signing this form, you are consenting to treatment** and, our use and disclosure of your (PHI) and (EHR) protected health information and along with electronic health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent, along with being posted in office. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Rathbone Chiropractic Center, Office. 4055 SW 185th Avenue, Suite 200 Aloha, OR 97078 503-642-1449
office@rathbonechiropractic.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature _____ ***Date***: _____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____ _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____ Date: _____

Authorization is given for _____ to have access to my Medical records.

Sign_____ Date_____